OFFICE OF MENTAL RETARDATION SERVICES
MR AND DS WAIVER INDIVIDUAL SERVICE AUTHORIZATION REQUEST
FAX SUBMISSION FORM

Must accompany all ISARs or resubmissions submitted by CSB

COMMUNITY SERVICES BOARD

DATE

Fax ALL submissions and resubmissions to:			
	ASSIGNED PA CONSULTANT	**FAX #**	**PHONE #**
	Darlene Lindsey	**804 – 786- 3283**	**804 – 371 - 0543**
	Lynn Burrill	**804 – 786- 6481**	**804 – 371 - 0544**
	Coretta Jones	**434 – 947- 2436**	**434 – 947 - 6080**
	Andrea Coleman	**804 – 371- 2581**	**804 – 371 - 2583**
	Cynthia Smith	**804 - 225 - 2260**	**804 - 786 - 0946**

CSB Contact Name: _____

CSB PHONE #	**CSB FAX #**

	Name(s) of Individual(s) for attached ISAR(s) and Preauthorization Documentation	**# Pgs.** ***DON'T count this cover sheet***	**✓ if Urgent**	**✓** if Resub-mission**	**MR OFFICE USE ONLY**			
					ISARs and resubmission info received at OMR		**Stamped and entered ISARs faxed back to CSB**	
					# pgs	Initials & Date	# pgs	Initials & Date
1								
2								
3								
4								
5								
6								
7								
8								

****Submitting additional information requested by the PA Consultant.**

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